
OLR Bill Analysis

sHB 5451

AN ACT CONCERNING HEALTH CARE POOLING.

SUMMARY:

This bill requires entities that issue or administer group health insurance policies for certain municipal employers, by October 1, 2014, and municipalities that sponsor these policies for their employees or retirees, by October 1, 2015, to begin annually submitting specific policy and claims-related information to the state comptroller. The information must cover policies providing (1) basic hospital or medical-surgical expense coverage, (2) major medical expense coverage, (3) hospital or medical service plan contracts, (4) hospital and medical coverage for health care center subscribers, and (5) single service ancillary health coverage.

The bill requires the comptroller to use this information to prepare an annual report that estimates the costs or savings available to the reporting municipal employers if they obtained group health insurance under the plan available to state employees (i.e., the Connecticut Partnership Plan). The comptroller must submit the reports to the Appropriations, Insurance and Real Estate, Labor and Public Employees, and Planning and Development committees, with the first report due by January 1, 2016.

The bill also allows the comptroller to (1) convene a temporary working group to develop health care provider payment reforms for the group health insurance plans offered to state employees and (2) enter into a cooperative agreement with certain group health insurers, administrators, and health care providers if he determines it will likely produce efficiencies and improve health care outcomes. The comptroller must report on the group's recommendations by January 1, 2016.

EFFECTIVE DATE: July 1, 2014

MUNICIPAL INSURERS' REPORT

By October 1, 2014, and annually thereafter, the bill requires certain entities to submit to the comptroller, for each covered municipal employer, the previous policy year's (1) complete medical, dental, and pharmaceutical utilization data, as applicable, and (2) annual claims paid, aggregated by practice type and service category, and reported separately for in- and out-of network providers and total number of claims paid. Covered municipal employers are municipalities and school, taxing, or fire districts, with at least 50 employees.

The reporting requirement applies to each insurer, health care center, hospital service corporation, medical service corporation, or other entity (1) delivering, issuing for delivery, renewing, amending, or continuing a covered employer's group health insurance policy and (2) providing either (a) only administrative services or (b) one of the specified types of coverage.

By law, policy issuers must provide this and other information to municipal employers upon request and the employer can provide it confidentially to the comptroller. The bill requires the reporting entities to submit this information electronically to the comptroller in a form prescribed by the comptroller, regardless of whether a covered municipal employer asked for the information. The disclosed information (1) can include only health information with identifiers removed, as required by federal regulations; (2) cannot be individually identifiable, as defined in federal regulations; and (3) must be allowed under the federal Health Insurance Portability and Accountability Act (HIPAA). The comptroller must maintain the disclosed information as confidential and it is not subject to disclosure under the state's Freedom of Information Act.

MUNICIPAL REPORT

By October 1, 2015, and annually thereafter, the bill requires municipalities that sponsor group health policies or plans that provide the types of coverage specified above for their active employees or

retirees to submit information to the comptroller. The required information, which must be submitted electronically in a form prescribed by the comptroller, is:

1. a list of each of the municipality's offered group health policies or plans and their specific details including (a) covered benefits and benefit limits, (b) total premium costs or premium equivalent costs for each policy or plan, organized by coverage tier, including single, two-person, and family, including dependents, and (c) the employee, early retiree, or retiree share for each total premium cost;
2. cost-sharing requirements, such as coinsurance, copayments, deductibles, and other out-of-pocket expenses associated with in-network and out-of-network providers;
3. the value of any prescription drug plan rebates or cost reductions;
4. the total number of employees, early retirees, and retirees in each policy or plan, organized by (a) municipal department, (b) collective bargaining unit, if applicable, (c) coverage tier, and (d) active employee, early retiree, or retiree status; and
5. the percentage change in per-person policy or plan costs over the preceding two policy or plan years.

The bill prohibits municipalities submitting this information from including health information in it.

COMPTROLLER'S WORKING GROUP

The bill allows the comptroller to convene a temporary working group, from July 1, 2014 to June 30, 2015, to develop and establish health care provider payment reforms for the group health insurance plans offered to state employees. The reforms can include multi-payer initiatives, patient-centered medical homes, primary care case management, value-based purchasing, and bundled purchasing.

The comptroller cannot require any parties to participate in the group, which can include:

1. health insurance companies, health care centers, hospital service corporations, medical service corporations, or other entities delivering, issuing for delivery, renewing, amending, or continuing group health insurance plans;
2. third-party administrators providing only administrative services for the state's self-insured plans;
3. health care providers;
4. health care facilities;
5. the Office of Policy and Management; and
6. state employees and retirees.

Working Group Survey and Meetings

The bill allows the comptroller, or his designee, to (1) survey the non-governmental entities eligible to participate in the working group about payment delivery reforms and (2) convene work group meetings at a time and place convenient to all of the participants. The comptroller, or his designee, must ensure that the survey and working group participants do not solicit, share, or discuss pricing information.

The bill specifies that the survey and working group meetings are not (1) violations of the state's Anti-Trust Act or (2) subject the state Freedom of Information Act's disclosure or notice requirements.

Cooperative Agreements

The bill allows the comptroller to enter into cooperative agreements with any of the non-governmental entities eligible to participate in the working group if he determines that it will likely produce efficiencies and improvements in health care outcomes. The agreements can be to (1) identify and reward high-quality, low-cost health care providers or (2) create incentives for enrollees to (a) receive care from such providers or (b) promote personal health behaviors that prevent or

effectively manage chronic diseases, including tobacco cessation, weight control, and physical activity.

The comptroller can establish guidelines for these agreements, which must be consistent with federal and state antitrust laws and the Federal Trade Commission's regulations.

Report

By January 1, 2016, the comptroller must report to the Appropriations, Labor, and Public Health committees on the working group's recommendations. The report must include (1) any cost containment measures, (2) descriptions of any quality measurement or quality improvement initiatives implemented on the working group's recommendation, and (3) any cost savings or health outcome improvements associated with these measures or initiatives.

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable Substitute

Yea 7 Nay 3 (03/18/2014)